CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
TABLE OF CONTENTS

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INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** – This section contains information about the timely filing of claims, claims inquiries, and supply procedures.
- **Billing Procedures** – Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

NORTHERN VIRIGNIA LOCALITIES

For purposes of billing rates provided under the Elderly and Disabled Waiver, the following are considered the Northern Virginia localities:

Alexandria
Arlington
Clarke
Culpeper
Fairfax
Fairfax City
Falls Church City
Fauquier
Fredericksburg City
King George
Loudon
Manassas City
Manassas Park City
Prince William
Spotsylvania
Stafford
Warren

RATES OF REIMBURSEMENT FOR PERSONAL CARE SERVICES

To comply with Federal and State mandates, a ceiling for the cost of personal care services has been calculated for regions of the State and must be applied uniformly on a statewide basis, according to the geographic location of the recipient. The fee for personal care services is an hourly fee, which reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. The personal care services hourly reimbursement rate (effective for dates of service on or after July 1, 2003) is:

Northern Virginia	$13.38 per hour
Rest of State	$11.36 per hour

The maximum number of hours, which can be billed, is the amount on the provider's approved plan of care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR RESPITE CARE SERVICES

To comply with Federal and State mandates, a ceiling for the cost of respite care services has been calculated for regions of the State and must be applied uniformly on a statewide basis according to the geographic location of the recipient. The unit of service for respite care will be defined by the number of hours of service, which are provided.

The hourly reimbursement rate for respite care services provided by a respite care provider (effective for dates of service on or after July 1, 2003) is:

Northern Virginia	$13.38 per hour
Rest of State	$11.36 per hour

When skilled nursing services are offered (as authorized) by a licensed practical nurse, the hourly rate of reimbursement is:

Northern Virginia	$26.00 per hour
Rest of State	$21.45 per hour

This reimbursement must cover all expenses associated with the delivery of respite care services.

The amount of respite care services required by each recipient shall be determined by the Pre-Admission Screening Team. This authorization for units of service will establish the maximum number of units and the allowable payment for the service.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE SERVICES

To comply with Federal and State mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the State and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per diem fee. A day is defined as attendance at the ADHC center for six hours

or more. The ADHC per diem reimbursement rate (effective for dates of service on or after July 1, 2003) is:

Northern Virginia	$47.25 per diem
Rest of State	$43.05 per diem

This fee must cover all expenses associated with the delivery of services for the time the recipient is attending an ADHC center. The per diem reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a recipient attends the ADHC center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per recipient. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC center which is able to provide recipients with transportation routinely to and from the center can be reimbursed by DMAS based on a per trip (to and from the recipient's residence) fee. This reimbursement for transportation must be preauthorized by either the Screening Team or the WVMI review staff. The per trip reimbursement rate is:

$2.00 per trip

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The rates of reimbursement for PERS installation is:

Northern Virginia	$59.00
Rest of State	$50.00

The one time installation of the unit includes installation, account activation, recipient and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring is:

Northern Virginia	$35.40 per month
Rest of State	$30.00 per month

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance and monitoring of the PERS.

PATIENT PAY AMOUNT AND COLLECTION

The patient pay amount is that amount of a Medicaid recipient's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the Department of Social Services based on the recipient's income and medically related deductions. It is the responsibility of the Department of Social Services to notify the recipient and the provider of any change in the patient pay amount. The provider should immediately initiate a DMAS-122 form and send it to the local Department of Social Services upon starting services so that the Department of Social Services can notify the provider of the actual patient pay amounts. Upon receipt of a referral in which a patient pay amount for services is indicated, the provider should verify that the recipient understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. DMAS will not reimburse the provider for any portion of the patient pay amount.

The personal care provider has total patient pay collection responsibility for recipients who have a patient pay responsibility and who have been approved for both adult day health care and personal care. In those instances where the patient pay responsibility usually exceeds the amount of personal care services authorized, the personal care provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to the adult day health care center and the amount the participant will pay monthly to the personal care provider. The personal care provider must provide a copy of this statement to the ADHC provider.

In the event that the recipient does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the recipient/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the recipient with copies sent to WVMI.

The recipient's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the provider must also notify the local Department of Social Services eligibility worker having case responsibility for the recipient. This notification must be in writing and a copy retained in the recipient's record by the provider. It is the provider's responsibility to collect patient pay amounts and to decide whether to continue service delivery to a recipient who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider for the patient pay amount.

If, after a reasonable effort to collect the patient pay amount, the provider decides to terminate services, the provider must give the recipient/family five days' written notice of termination of services, such notice must include the reason for termination and the effective date. A copy of this notification must be sent to the local Department of Social Services eligibility worker. A copy of all correspondence must be retained by the recipient's provider in the record and a copy sent to DMAS.

The patient pay amount is the recipient's contribution toward his or her care received in a calendar month. If the amount of services rendered to a recipient is equal to or less than such recipient's patient pay amount, only the amount for the services rendered should be collected from the recipient, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount.

Any time a new DMAS-122 is received, it is the provider's responsibility to note any changes in the amount to be collected from the recipient and bill accordingly.

MEDICAID BILLING INVOICES FOR ELDERLY AND DISABLED WAIVER SERVICES

The billing invoice for E&D Waiver services is the CMS-1500 (12-90).

SUBMISISON OF BILLING INVOICES

Agencies must submit claims using the actual dates of service rendered. Invoices must include only allowable charges for the number of hours for services rendered. Any charges submitted prior to the date authorized by the Screening Team as the begin date will be rejected. Invoices must be submitted in the purple-edged, self-addressed envelope provided by DMAS. The provider copy of the invoice must be retained by the provider for record keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to the Department of Medical Assistance Services address; this will only delay processing. Providers should allow at least 30 days for claims processing.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800) 924-6741
Fax number: (804)-273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING OF CLAIMS

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which are not submitted within 12 months from the date of the service. The DMAS-3 form is to be used by electronic billers for attachments. (See "Exhibits") Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility -** Medicaid eligibility can begin as early as the first day of the third month prior to the date the application for benefits is filed. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility -** Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the recipient prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local Department of Social Services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of receipt of the notification of the delayed eligibility. A copy of the dated letter from the local Department of Social Services indicating the delayed claim information must be attached to the appropriate claim. If the claim is filed on the CMS-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Denied Claims** - Denied claims which have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 (12-90) invoice as explained under the "Instructions for the Use of the CMS-1500 (12-90) Billing Form" and see the sample form in the "Exhibits" section at the end of this chapter.

  - Attach written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month time period.

  - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (12-90) claim form.

  - Mail claims to:

    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

    Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

    The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria.

- **Accident Cases** – The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier

after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive period, after-the-fact authorizations will be performed by DMAS.

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (12-90) BILING FORM

To bill for services, the Health Insurance Claim Form, CMS-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500. The required and conditional fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found at the end of this chapter.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (12-90) Billing Invoice

The purpose of the CMS-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of CMS-1500 claim form follows the instructions for its use).

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name

9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED).** **a. Employment b. Auto Accident c. Other Accident (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED**	**Date of Current Illness, Injury, or Pregnancy (Date care began, located on the DMAS-93 form)**
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the 7-digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**

18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab
21	**REQUIRED**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis, which describes the nature of the illness or injury for which the service was rendered.**
22	**CONDITIONAL**	**Medicaid Resubmission - Required for adjustment and void invoices. See the instructions for Adjustment and Void Invoices.**
23	**REQUIRED**	**Prior Authorization Number - Enter the PA number for the approved service.**
24A	**REQUIRED**	**Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/02). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.**
24B	**REQUIRED**	**Place of Service - Enter the 2-digit CMS Code, which describes where the services were rendered.**
24C	**REQUIRED**	**Type of Service - Enter the one-digit CMS Code for the type of service rendered.**
24D	**REQUIRED**	**Procedures, Services or Supplies.** **CPT/HCPCS - Enter the 5-character CPT/HCPCS Code, which describes the procedure rendered, or the service provided. See the attached code list for special instructions if appropriate for your service.** **Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry. NOTE: Use modifier "22" for individual consideration. Claims will pend for manual review of attached documentation.**
24E	**REQUIRED**	**Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.**

24F	**REQUIRED**	**Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.**
24G	**REQUIRED**	**Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.**
24H	**CONDITIONAL**	**EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.** **1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services** **2 - Family Planning Service**
24I	**CONDITIONAL**	**EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**
24J	**REQUIRED**	**COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.** **2 - No Other Carrier** **3 - Billed and Paid** **5 - Billed, No Coverage**
24K	**REQUIRED**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.**
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number – Up to Seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge

29	**CONDITIONAL**	**Amount Paid – Enter patient pay amount for personal care only**
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered.
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your Virginia Medicaid provider number (servicing provider) in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code. Enter Group# (billing provider number) if applicable.**

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (12-90), AS AN ADJUSTMENT INVOICE

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 — Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

INSTRUCTIONS FOR THE COMPLETION OF HEALTH INSURANCE CLAIM FORM, CMS-1500 (12-90), AS A VOID INVOICE

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong recipient eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Recipient not my patient
1052 Void is for miscellaneous reasons
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim).

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM

The primary care physician (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter I under CMM). Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted enrollee is treated on referral from the primary physician, enter the primary physician's Medicaid provider number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Follow the instructions for the 837 transaction and the standard for attachments using the Claim Attachment Form (DMAS-3).

SPECIAL BILLING INSTRUCTIONS MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual*.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the CMS-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 Date of Current Illness, Injury, or Pregnancy

Date care began is located on the DMAS-93 (P.A. Letter)

Locator 24D Procedures, Services or Supplies

CPT/HCPCS - Enter the appropriate procedure code from the following list:

T1019 Personal Care

T1005 Respite care services, aide/hr.

S9125 Respite care services, LPN/hr.

Locator 24J COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay).

Locator 24K Reserved for Local Use

Enter the patient pay amount except for Personal Care. (For Personal Care see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

Locator 29 Amount Paid

Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE

The providers of ADHC must complete the CMS-1500 (12-90) claim form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D — CPT/HCPCS - Enter the appropriate procedure code from the following list for the service rendered:

S5102 Adult Day Health Care Services

A0120 Adult Day Health Care Transportation

Locator 24J — COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

Locator 24K — Reserved for Local Use

Enter the patient pay amount or payment from other insurance, if applicable.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D **Procedures, Services or Supplies**

CPT/HCPCS – Enter the appropriate procedure code from the following list:

S5160 **PERS Installation**

S5161 **PERS Monitoring**

Locator 24K **Reserved for Local Use**

Enter the payment from other insurance, if applicable.

Providers of PERS services for the Elderly and Disabled Waiver must submit their CMS-1500 and approval letter from WVMI to the following address until further notice:

DMAS
Customer Services Unit Supervisor
Division of Program Operations
600 E. Broad Street, Suite 1300'
Richmond, Virginia 23219

LOCAL TO NATIONAL CODE CROSSWALK

Below is a listing of the old local codes that are replaced with the new national codes as required by HIPAA. Local codes will be accepted for claims with dates of service through December 31, 2003. National codes are optional for claims with dates of service on or before December 31, 2003, but are mandatory for claims with dates of service on or after January 1, 2004.

Old Code	New Code	
Z4036	T1019	Personal Care
Z9421	T1005	Respite care services, aide/hr.
Z9423	S9125	Respite care services, LPN/hr.
Z9410	S5102	Adult Day Health Care Services
Z9412	A0120	Adult Day Health Care Transportation
Y0071	S5160	PERS Installation
Y0073	S5161	PERS Monitoring

PREAUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

PATIENT INFORMATION FORM (DMAS-122)

Purpose

This form is used by a local Department of Social Services and an Elderly and Disabled Waiver services provider to exchange information with respect to:

- the responsibility of an eligible recipient to make payment toward the cost of care;
- the admission or discharge of the recipient or death of the recipient; and
- other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local Department of Social Services of changes in the recipient's circumstances. A new form must be prepared by the local Department of Social Services at the time of each redetermination of eligibility and whenever there is any change in the recipient's circumstances that results in a change in the amount of the patient pay.

Disposition of Copies

The provider should initiate the form upon receiving a referral from the Pre-Admission Screening Team in order to notify the local Department of Social Services that he or she has admitted the recipient and to provide the beginning date of service. Upon determination of eligibility, the DMAS-122 will be returned to the provider with the following information:

- whether the recipient does or does not have financial responsibility toward the cost of care;
- the amount and sources of finances; and
- the date on which the patient pay responsibility begins.

There must be a completed DMAS-122 form in the recipient's file prior to billing DMAS.

REPLENSIHMENT OF BILLING MATERIALS

The CMS-1500 (12-90) is a universally accepted claim from that is required when billing for DMAS covered services. The form is available from forms printers and the U.S. Government Printing Office. The CMS-1500 (12-90) will not be provided by DMAS. Specific details on purchasing the CMS-1500 (12-90) forms can be obtained by writing to the following address:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 51250-7954

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.state.va.us). To access the forms, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1-804-780-0076.

IMPORTANT:

- When billing on the CMS-1500 (12-90), Virginia Medicaid will accept an original form printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Additionally, only the CMS-1500 (12-90) form will be accepted; no other CMS-1500 form will be accepted.

- The requirement to submit claims on an original CMS-1500 (12-90) or two-sided laser printed form is necessary because the individual signing the invoice is attesting to the statements on the reverse side, and, therefore, these statements become part of the original billing invoice.

COMPUTER-GENERATED INVOICES

Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines. Electronic Data Interchange (EDI) is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing.

Providers wishing approval to submit electronic media claims should write to the Coordinator of Electronic Media Claims who will advise the proper steps for accomplishing this type of billing. The address to be used is:

Coordinator
Electronic Media Claims
FIRST HEALTH Services Corporation
4300 Cox Road
Glen Allen, Virginia 23060

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (888) 829-5373 and choose Option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by using the Web-based Automated Response System. See Chapter 1 for more information.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will no longer be accepted for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before December 31, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after January 1, 2004.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

TURNAROUND DOCUMENT LETTER (TAD)

If lines on an invoice are completed improperly, a computer-generated letter (TAD) is sent to the provider to correct the error. The TAD should be returned to First Health. The claim will be denied if the TAD is not received in the system within 21 days. Only requested information should be returned. Additional information will not be considered and may cause the claim to deny in error.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).

- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

EXHIBITS

TABLE OF CONTENTS

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)* **M M D D C C Y Y** **Date of Service** **Sequence Number (5 digits)**

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS – 3

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 123456789070120031 2345).

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

ATTACHMENTS ARE SENT TO THE SAME MAILING ADDRESS USED FOR CLAIM SUBMISSION. USE APPROPRIATE PO BOX NUMBER. MAILING ADDRESSES ARE AVAILABLE IN THE PROVIDER MANUALS OR CHECK THE DMAS WEBSITE AT WWW.DMAS.STATE.VA.US.